RETIRED CHANGE OF STATUS APPLICATION

State Health Benefits Program - School Employees' Health Benefits Program
New Jersey Division of Pensions and Benefits
P.O. Box 299 • Trenton, NJ 08625-0299

HR-0809-0908

1. APPLICANT INFORMATION

Social Security Number ___ – ___ – ____

Last Name _____ Title (Jr., Sr., etc.) ___

First Name _____ Middle Name _____

Street Address _____ Apartment # ___

PO Box ___ City _____ State __

Zip Code + 4 _____ – ____ Date of Birth (mm/dd/yy) ____ Gender (M/F) _

Status (check one) ☐ Single ☐ Married ☐ Civil Union (see instructions) ☐ Divorced ☐ Widowed ☐ Domestic Partnership (see instructions)

Former Employer _____

Area Code ___ Home Telephone Number ___ – ____ Date of Retirement (mm/dd/yy) ____

	YES	NO
Do YOU have Medicare Part A? (Hospital Insurance)		
Do YOU have Medicare Part B? (Medical Insurance)		
Does YOUR SPOUSE/PARTNER have Medicare Part A?		
Does YOUR SPOUSE/PARTNER have Medicare Part B?		

Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits for at least 24 months) must be enrolled under both Medicare Part A (Hospital) and Part B (Medical) in order to continue coverage under this program. If enrolled, a photocopy of the Medicare card must be submitted with this application.

If your child has Medicare, list child's name and Social Security Number _____ and attach a copy of the Medicare card.

2. TYPE OF ACTIVITY — Check one box in Section 2A; If you select ***Plan Change,*** complete Sections 2B; *3, 4, and 5; for* ***Dependent/Coverage Level Change,*** complete Section 2B and 5; for ***Other Changes,*** complete Section 2C; if you select ***Cancel Coverage,*** go to Sections 3 and 4.

2A. COVERAGE ACTION REQUESTED

☐ Plan Change ☐ Dependent/Coverage Level Changes
☐ Other Changes ☐ Cancel Coverage

2B. PLAN/DEPENDENT/COVERAGE LEVEL CHANGES

Medical Plan Change — From _____ To _____

	Month	Day	Year
Marriage — Attach Marriage Certificate (Give Date of Event) Former Name _____			
Civil Union or Domestic Partnership — Attach Certificate of Civil Union or Certificate of Domestic Partnership (Give Date of Event)			
Birth of Child (Give Date of Event)			
Adoption/Guardianship — Proof Required (Give Date of Event)			
Deletion of Dependent (Give Date of Event)			

Dependent's name: _____ SS# _____

Reason for Deletion: ☐ Death of Spouse/Partner ☐ Divorce ☐ Dissolution of Civil Union or Domestic Partnership ☐ Other _____

2C. OTHER CHANGES

☐ Spouse/Partner's Health Benefits terminated with employer - Attach letter from employer
☐ Change in last name only (Give Former Name) _____
☐ Correction to Social Security # — Attach copy of Social Security Card (Give Former Social Security #) _____
☐ Change in Birth Date (Give Name and Correct Date) — Attach copy of Birth Certificate _____
☐ Addition of dependent's Social Security # (List the dependent(s) in Section 5)
☐ Other: Give Reason (i.e., address change, dependent returns from military service, etc.) _____

3A. MEDICAL COVERAGE (Check one box only).

☐ I wish to change my coverage to **NJ DIRECT15**
☐ I wish to change my coverage to **NJ DIRECT10** (Certain State retirees may be ineligible for NJ DIRECT10. See the *NJ DIRECT Member Handbook* for eligibility information.)
☐ I wish change my coverage to **Aetna HMO.** (Enter Aetna HMO Primary Care Physician's ID#) _____
☐ I wish to change my coverage to **CIGNA HealthCare.** (Enter CIGNA Primary Care Physician's ID#) _____
☐ **I do not wish to be covered** under any of the medical plans (See instructions)
☐ **I wish to waive coverage** under the medical plans for the following reason: (See instructions)
☐ I have coverage with another employer ☐ I have coverage with spouse/partner's employer
List Employer _____
☐ Other (Give Reason) _____

3B. LEVEL OF COVERAGE (Check one box)

☐ Single ☐ Member & Spouse/Civil Union Partner (See Instructions)
☐ Family ☐ Parent/Child(ren) ☐ Member & Domestic Partner (See Instructions)

4A. DENTAL COVERAGE

☐ I wish to be covered by the **Retiree Dental Expense Plan** *(Only permitted if Retiree Dental Expense Plan enrollment was previously waived.)*
☐ **I do not wish to be covered** under the dental plan (See instructions)
☐ **I wish to waive coverage** under the dental plan for the following reason: (See instructions)
☐ I have coverage with another employer ☐ I have coverage with spouse/partner's employer
List Employer _____

4B. LEVEL OF COVERAGE (Check one box)

☐ Single ☐ Member & Spouse/Civil Union Partner (See Instructions)
☐ Family ☐ Parent/Child(ren) ☐ Member & Domestic Partner (See Instructions)

4C. PREVIOUS DENTAL COVERAGE

Were you enrolled in a group dental plan for at least 12 months prior to retirement? ☐ Yes ☐ No
If yes, please provide Dental Plan Name, Telephone Number, and your Dental Plan ID Number:
_____

5. DEPENDENT INFORMATION — List eligible dependents you wish to include on your coverage. If necessary, attach another sheet of paper.

	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
☐ Spouse/Partner								
Eligible Children								

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Event Reason ☐ Effective Date ____
Waiver Code ☐ Location No. ____
Waiver Codes: 3 - (voluntary) 4 - (non-response) 5 - (spouse) 6 - (employer)

6. I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check, including initial check, last check benefit, withdrawal check, or return of contributions check as required by the State Health Benefits Commission or School Employees' Health Benefits Commission. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the NJ DIRECT or HMO plans. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical/dental plan or its assignee with such medical/dental information about myself, or my covered dependents on this application, as the assignee may require. I further authorize my current dental plan, if applicible, to release information deemed necessary for enrollment in this plan. **Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. PROOF OF ENROLLMENT IS REQUIRED.** If I or a covered dependent enroll in Medicare at a later date, I understand that the Health Benefits Bureau must be notified immediately.

Applicant's Signature _____ Date: _____

☐ Additional Sheet Attached ☐ Medicare Proof Enclosed

COMPLETING THE RETIRED CHANGE OF STATUS APPLICATION

THIS APPLICATION IS FOR CHANGES TO COVERAGE BY CURRENTLY ENROLLED RETIREES WHO ARE MEMBERS OF THE STATE HEALTH BENEFITS PROGRAM (SHBP) OR SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM (SEHBP).

If you have recently applied for retirement and are a new enrollee to the SHBP or SEHBP, *DO NOT USE THIS FORM.*
New enrollees should complete the *Retired Coverage Enrollment Application.*

SECTION 1 — APPLICANT INFORMATION

This section pertains to the person enrolling in the retired group of the SHBP or SEHBP. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth and Date of Retirement (for example: April 12, 1933 = 04 12 33).

SECTION 2 — TYPE OF ACTIVITY

Check one box in section 2A.

For plan changes, check "Plan Change" and list the plan names in the "From" and "To" area of section 2B, and continue in sections 3, 4 and 5 if applicable.

To add or delete a dependent, check "Dependent/Coverage Level Change" and enter the change information in section 2B, 3, 4 and 5.

For other changes check "Other Change" enter the change information in section 2C.

Coverage can be voluntarily cancelled at any time by checking "Cancel Coverage." However, if you voluntarily cancel your coverage, reinstatement into the State Health Benefits Program or School Employees' Health Benefits Program is not normally permissible.

SECTION 3 — MEDICAL PLAN SELECTION

Check only one box indicating: **1.**) The medical plan that you want to change to — when changing to a HMO plan you must list the identification number (ID #) of your Primary Care Physician; or **2.**) That you do not want medical plan coverage (See "Declining, Canceling, or Waiving Coverage" below); or **3.**) That you want to waive medical plan coverage. (See "Declining, Canceling, or Waiving Coverage" below)

DECLINING, CANCELING, OR WAIVING COVERAGE — If you are declining or canceling coverage and do not want SHBP or SEHBP coverage, check the box indicating that you do not wish to be covered under any of the medical/dental plans.

If you are requesting to waive enrollment for yourself and any of your eligible dependents because of other group health or dental insurance coverage from a public or private employer, check the box indicating that you wish to waive coverage, indicate if the coverage is through your employment or that of your spouse/partner, and the name of the employer. If coverage is waived you may in the future be able to enroll yourself and your eligible dependents in a SHBP or SEHBP medical or dental plan, provided that you request enrollment within 60 days after your other employer group health or dental coverage ends — proof of loss of coverage is required. See Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, for more information. Police and Firemen's Retirement System (PFRS) members enrolling under Chapter 330, P.L. 1997 should refer to Fact Sheet #47, *Retired Health Benefits Coverage Under Chapter 330*, for more information.

LEVEL OF COVERAGE — Select a level of coverage based upon who you will be covering. Your eligible dependents are your spouse or civil union partner (attach a copy of the *Marriage Certificate* or *Certificate of Civil Union* if this is your first time enrolling in the SHBP or SEHBP), or an eligible same-sex domestic partner (see definition below), and your unmarried children under age 23 who live with you in a regular parent-child relationship. (This includes children who are away at school.) If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. Step children, foster children, legally-adopted children, and legal wards are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. An *Affidavit of Dependency* form and legal documentation are required for these cases if you have not previously provided this to the Health Benefits Bureau. You will be sent an *Affidavit of Dependency* if required once your application is received.

Dependents may be added within 60 days of the date of event (i.e., marriage, civil union, birth of a child) with an effective date of the date of the event. Otherwise, eligible dependents can be added in the future, with a 60-day waiting period. Coverage will be effective the 1st of the month following the 60 days of the receipt of your application.

Indicate whether you and/or your spouse/partner and/or child are enrolled in Medicare Parts A and B. Be sure to list the effective dates of the Medicare enrollment. Proof of full Medicare enrollment in Parts A and B is required by the Health Benefits Bureau. Please submit a photocopy of the Medicare card or a letter from Social Security confirming the effective dates of full Medicare enrollment. Members receiving a Social Security Disability who become Medicare eligible, must be enrolled in the full Medicare program — Part A and Part B — in order to have coverage in the SHBP or SEHBP. If submitting proof of Medicare enrollment, check the box at the bottom right of the application.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* is required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions is required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see Fact Sheet #75, *Civil Unions,* for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP or SEHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners is required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

SECTION 4 — DENTAL EXPENSE PLAN SELECTION

Enrollment in the Retiree Dental Expense Plan is only permitted when first eligible at retirement **or if enrollment was waived** due to other group dental coverage. Check only one box indicating: **1.**) that, if eligible, you want to enroll in the Retiree Dental Expense Plan; or **2.**) That you do not want dental coverage (See "Declining, Canceling, or Waiving Coverage" above); or **3.**) That you want to waive dental coverage. (See "Declining, Canceling, or Waiving Coverage" above)

If eligible to enroll or add a dependent, select a level of coverage based upon who you will be covering. See "Level of Coverage" above.

SECTION 5 — SPOUSE/PARTNER AND DEPENDENT INFORMATION

This section is used for members selecting Member & Spouse/Partner, Family, or Parent & Child(ren) coverage. Please list your spouse/partner's name, gender, date of birth, Social Security number, and if enrolling in an HMO plan the spouse/partner's Primary Care Physician Identification Number. Please also list the name, gender, date of birth, Social Security number, and if enrolling in an HMO plan the Primary Care Physician Identification Number for any dependent children you are enrolling. If you are listing more than two children, please provide the required information for your other children on an additional sheet of paper, attach the sheet to the application, and check the box at the bottom right of the application.

SECTION 6 — CERTIFICATION AND SIGNATURE

The member must read the certification and sign and date the application. If Medicare proof or additional sheets are submitted with the application, check the box indicating such.

Misrepresentation: Any person who provides false or misleading information is subject to criminal and civil penalties.

Return this application and all supporting documentation to:

NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. BOX 299
TRENTON, NJ 08625-0299